Maple Knoll Communities
Hemsworth Wellness Center
Membership Contract

thehemsworth WELLNESS CENTER

Healthways SilverSneakers® Fitness Program

MindBody#_____ EMPLOYEE#_____

Date:_____ DOB:_____ Age:_____ Height:_____ Weight:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____ City:_____Zip:_____

Phone #:_____ Emergency #:_____ Male:_____ Female:_____

Physician Name: _____ Physician#:_____

MKC Resident: IL_____AL_____ Community Member:_____ Employee:_____ Meadows:_____

Fees: New Members will be charged a $50.00 one-time enrollment fee.
Please select your membership option below.

_____ **Community Single** **(Prepay)** _____ **(Draft)** _____

_____ **Community Couple** **(Prepay)** _____ **(Draft)** _____

_____ **Meadows Single** **(Prepay)** _____ **(Draft)** _____

_____ **Meadows Couple** **(Prepay)** _____ **(Draft)** _____

_____ **Employee Single** **(Prepay)** _____ **(Draft)** _____

_____ **Employee Couple** **(Prepay)** _____ **(Draft)** _____
***Add $40 for each additional Member.**

_____ **Silver Sneakers** **(Basic)** _____ **(Plus)** _____**($20 PerMonth)**
($30 Couple)

****Please Note: If you choose the Draft Option Please Fill Out the Back of this Form****

Start Date of Contract:_____ Experation Date:_____

$_____ + $_____ = $_____
Yearly Dues Tax Total Due

1. Member Signature_____ Date:_____

2. Wellness Center _____ Date:_____

Mind Body Fitness Software
Maple Knoll Communities - The Hemsworth Wellness Center
(Auto Draft Form)

I (we) hereby authorize Maple Knoll Communities - The Hemsworth Wellness Center, hereinafter called COMPANY, to initiate credit/debit entries to my (our) account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit/debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution Name Branch:_____

Address City:_____ State: _____ Zip Code: _____

_____ _____ _____

Routing Number Account Number Type of Account

This authority is to remain in full force and effect until Maple Knoll Communities - The Hemsworth Wellness Center has received written notification from me (or either of us) of the amount indicated in the monthly contract. I/We acknowledge that this membership may not be terminated and that the payment is due in full at the end of your contractual agreement.

_____ _____/____/_____

Print Individual Name Signature Date

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM HERE!

Thank You for Signing up for Automatic Draft through Mind Body Fitness Software & Maple Knoll Communities - The Hemsworth Wellness Center.

Hemsworth Wellness Center at Maple Knoll Village
Physician's Consent Form
Information Requested For:

_____

Physician Name: _____ **Physician's License #:** _____

Physical Health Status: Please indicate health status indicator:

		Low	Normal	High
_____	Height	-	-	-
_____	Body Weight	L	N	H
_____	Resting Heart Rate	L	N	H
_____	Blood Pressure	L	N	H

May individual use a 104 degree whirlpool/spa? **No** **Yes**

Time Limit: _____ (Maximum of 10 minutes)

II. Physician's Statement of Restrictions (if any)

( ) The above named individual may participate, without restriction, in all activities offered at the Hemsworth Wellness Center.

( ) The above named individual may participate, with restriction, in limited activities offered at the Hemsworth Wellness Center. (Fitness & aquatic staff will design a physical activity program for the individual based on the stated physical restrictions.)

Restriction and justifications:

_____

_____

( ) The above named individual may not participate in physical activities offered at the Maple Knoll Wellness Center.

III. This consent form is valid for 12 months.

Phone Number:_____ Fax Number:_____

Physician's Signature: _____ Date: _____

Wellness Center Member Statement (Signature/Date)

_____/_____I have read or been informed of the above Physician's Consent Form. I agree to adhere to any restrictions or limitations noted.

_____/_____I have completed the Health and Wellness Questionnaire and **WAIVE** the recommendation to provide a completed Physician's Consent

HEMSWORTH WELLNESS CENTER
OFFICE PHONE – 513-782-4340
FAX NUMBER – 513-782-2704

Maple Knoll Wellness Center
Health & Wellness Questionnaire

ALL MEMBERS: We recommend you have your physician review this part of the Health And Wellness questionnaire and complete the **Physician Consent Form.**

Today's Date:_____ DOB:_____ Height:_____ Weight:_____

Last Name:_____ First Name:_____

Male:_____ Female:_____ Phone #:_____

MKC Resident: IL_____AL____ Community Member:_____ Employee:_____ Meadows:_____

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Please note

At The Hemsworth Wellness Center, our programs are designed for your comfort and enjoyment. Please go at your own pace and do only as you are able. If you feel uncomfortable at any time during any program, we encourage you to inform the instructor and, if necessary, you may leave at any time. If there are circumstances or accommodations we could make so that your participation in our Wellness Program is both comfortable and enjoyable, please notify our fitness staff for any suggestions you have.

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Renewing Members Only: Have you had ANY previous condition changes or have ANY NEW conditions develop within the last year? YES _____ NO _____

If Yes, please indicate below, and if NO you may stop here.

	YES	*NO*	
1.	_____	_____	Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
2.	_____	_____	Do you feel pain in your chest when you do physical activity?
3.	_____	_____	In the past month, have you had chest pain when you were not doing physical activity?
4.	_____	_____	Do you lose balance because of dizziness or do you ever lose consciousness?
5.	_____	_____	Do you have a bone or joint problem that could be made worse by a change in your physical activity?
6.	_____	_____	Is your doctor currently prescribing drugs for blood pressure or heart condition?
7.	_____	_____	Do you know of any other reason why you should not do physical activity?

The Hemsworth Wellness Center

AHA/ACSM Health/Fitness Facility Pre-participation Screening Questionnaire

Please mark each statement that applies to your health status

HAVE YOU HAD:

_____ Heart Attack
_____ Heart Surgery
_____ Cardiac catheterization coronary
_____ Angioplasty (PTCA)
_____ Pacemaker/implantable cardiac defibrillator
_____ Rhythm disturbance
_____ Heart valve disease
_____ Heart failure
_____ Heart transplantation
_____ Congenital heart disease
_____ Joint Replacement's
Specify:_____

HEARING:

Do you have a hearing impairment?
Yes ____ No ____
Do you wear a hearing aid
Yes ____ No ____

VISION:

Do you have a vision impairment?
Yes ____ No ____
Are you able to read newsprint?
Yes ____ No ____

Primary Device you use:

NONE ____ Walker ____
Wheelchair ____ Cane ____

CARDIOVASCULAR RISK FACTORS:

_____ Your blood pressure is >130/90
_____ You do not know your blood pressure.
_____ You take blood pressure medication.
_____ Your blood cholesterol level is >200
_____ You do not know your cholesterol level.
_____ You are physically inactive (i.e., you get <30 minutes of physical activity on at least 3 days per week)
_____ You are greater than 20 pounds overweight
_____ You are none of the above.

OTHER HEALTH ISSUES:

_____ You have diabetes
_____ You have asthma or other lung disease
_____ You have burning or cramping sensation in your lower legs when walking short distances
_____ You have musculoskeletal problems that limit your physical activity.
_____ You have concerns about the safety of exercise
_____ You take prescription medications.
Specify: _____

_____

Goals:_____

Assumption of Risk
(Please Read Carefully)

I assume all the risks of using the Hemsworth Wellness Center. I voluntarily and knowingly participate in any or all of the programs sponsored at the Hemsworth Wellness Center. Additionally, I voluntarily waive any and all present and future claims resulting from negligence.

For myself and my heirs, assigns, beneficiaries, estate, and legal representatives, I hereby release and indemnify the Hemsworth Wellness Center, its affiliates, officers, trustees, agents, employees, representatives, successors and assigns from any and all claims of whatever nature arising from y death, personal injury or property damage related to my use of the Hemsworth Wellness Center or participating in aquatic programming, resistance training, cardio respiratory endurance training, body awareness, and wellness programming; or in any activities incidental to such aquatic programming, resistance training, cardio respiratory endurance training, body awareness, and wellness programming. This release shall remain in full force and effect for the entire length my membership is valid.

I hereby acknowledge that I may have health/medical limitation that could be discovered during the fitness assessment/physician clearance process that could affect or deter my ability to withstand strenuous exercise, or to place stress on any specific part of my body. I hereby consent and agree to assume all responsibility for any and all risks of injury with respect to such physical conditions, and my current health status.

Name (Print) :_____Date:_____

Name (Signature) :_____

Wellness Center Staff:_____ Date:_____

PLEASE TAKE IN CONSIDERATION

****If you marked two or more of the statements in the Health Questionnaire (PARQ) section, the center recommends an exercise program at The Hemsworth Wellness Center with a professionally qualified Personal Trainer.****

TO SET UP AN APPOINTMENT PLEASE CALL:

513-782-4340

Waiver and Assumption of Risk

Please consult with your physician before beginning any exercise program.

I acknowledge that I have voluntarily chosen to participate in one or more physical exercise or fitness activity or sport programs (the "Programs"). I acknowledge (i) the nature of the risks of the particular Programs in which I have chosen to participate, and (ii) the strenuous nature of those Programs. I understand, for example, the risks associated with physical injury, abnormal blood pressure, heart attack and even death; as well as the risks associated with the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the Programs, including, but not limited to, the negligence of a Healthways participating location and any other organization or individual participating or involved in providing or promoting any classes, functions, Programs, testing, or other activities that I participate in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue any class instructor, any Healthways participating location, any sponsoring organization, Healthways, Inc., or any of their subsidiaries or any other organization or individual providing or promoting classes, functions, Programs, testing, or other activities that I participated in as a Healthways Program member (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death, bodily injury or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read and understand this waiver and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location or individual.
In the event that my physician has recommended any limitations to my physical activity or I have experienced any of the following conditions, I hereby attest that I have informed my physician of the condition(s) and have obtained express consent from my physician to participate in the Programs.

- Chest pains while at rest and/or during exertion, previous heart attack or high blood pressure
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Diabetes
- Previous hip or spinal fracture (as an adult)
- Lung disease or shortness of breath after mild exertion, at rest, or in bed
- Open cuts on my feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- More than two falls in the past year (no matter what the reason)
- More than one year since I have engaged in regular physical activity

_____	_____/____/____
Print Member's	Name Member's Signature Date
_____	_____
Emergency Contact Name	Contact Phone Number